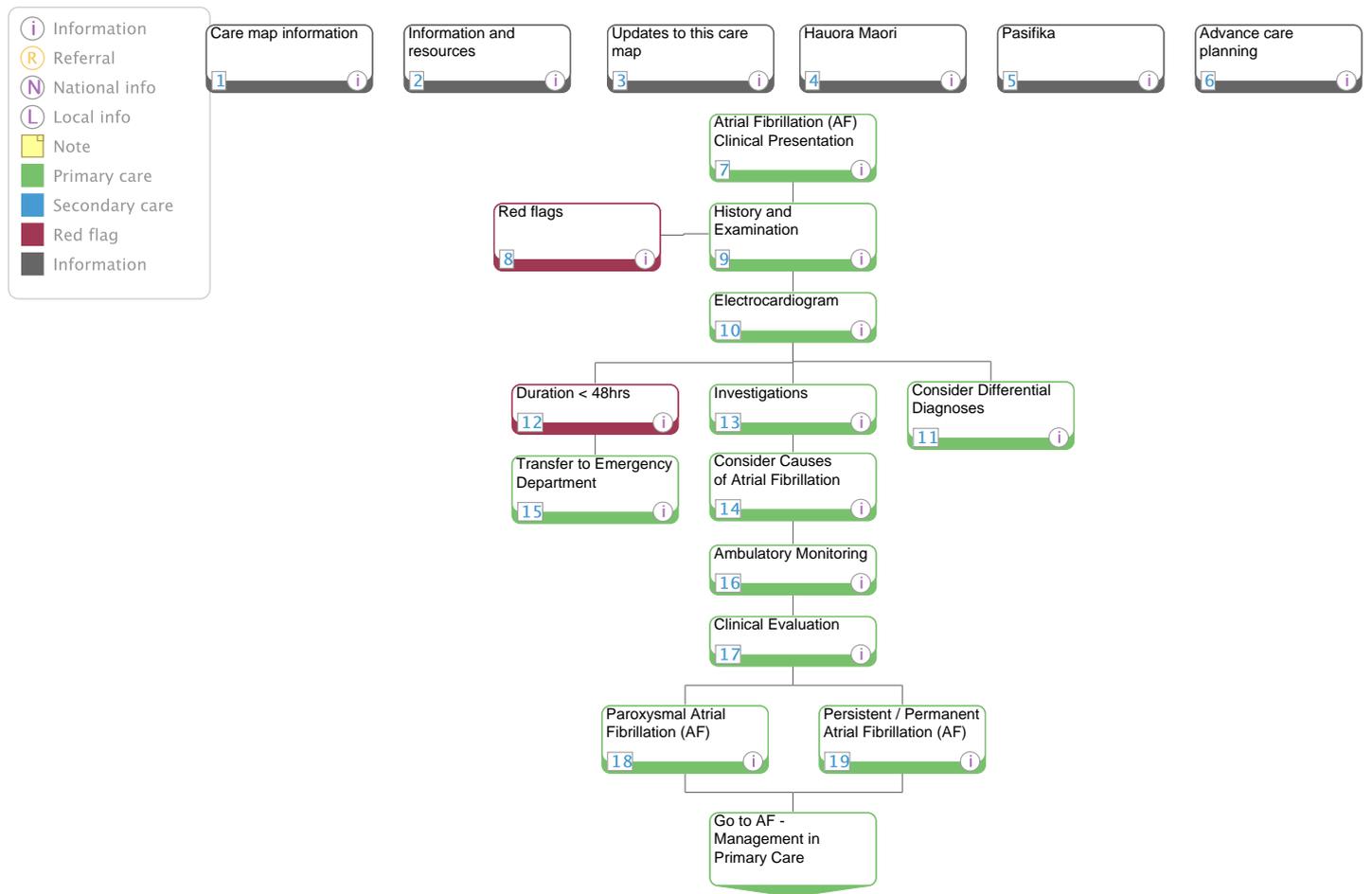


Atrial Fibrillation (AF) - Suspected

Medicine > Cardiology > Atrial Fibrillation



Atrial Fibrillation (AF) - Suspected

Medicine > Cardiology > Atrial Fibrillation

1 Care map information

Quick info:

Scope:

- the assessment and diagnosis of adults presenting with Atrial Fibrillation (AF), including
- consideration of stroke risk stratification and antithrombotic therapy
- referral criteria for cardiology

Out of scope:

- the assessment and management of AF in children
- postoperative AF
- AF following an ischaemic event

Definition:

- AF is an atrial tachyarrhythmia characterised by predominantly uncoordinated atrial activation with consequent deterioration of atrial mechanical function [1]
- defined on an electrocardiogram by the absence of consistent P waves – instead there are rapid oscillations or fibrillatory waves that [1]:
 - vary in size, shape, and timing
 - are generally associated with an irregular ventricular response when atrioventricular (AV) conduction is intact

Incidence and prevalence:

- Atrial fibrillation is one of the most common heart rhythm disorders in adults, especially in older people. It occurs:
 - in about 1 in every 100 people in the general population
 - in nearly 10 in every 100 people over 80 years of age
 - more commonly at a younger age in Maori and Pacific peoples than in other New Zealanders
 - incidence is substantially higher in those with cardiovascular disease (CVD) or valvular heart disease
 - prevalence is estimated to at least double in the next 50 years as the population ages [2]

Aetiology:

- often caused by co-existing medical conditions – both cardiac and non-cardiac
- common cardiac causes include [1]:
 - ischaemic heart disease
 - rheumatic heart disease - specifically mitral valve disease
 - hypertension
 - sick sinus syndrome
 - pre-excitation syndromes, eg Wolff-Parkinson-White
- less common cardiac causes include [1]:
 - cardiomyopathy or heart muscle disease
 - pericardial disease, including effusion and constrictive pericarditis
 - atrial septal defect
 - atrial myxoma
- non-cardiac causes include [1]:
 - acute infections, especially pneumonia
 - electrolyte disturbances
 - lung carcinoma
 - other intrathoracic pathology, eg pleural effusion
 - pulmonary embolism

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- thyrotoxicosis

Risk factors include:

- increasing age:
 - the prevalence of AF roughly doubles with each advancing decade of age, from 0.5% at age 50-59 years to approximately 10% in people aged greater than 80 years
- Ethnicity - Maori & Pacific People
- diabetes mellitus
- hypertension
- symptomatic heart failure [2]:
 - present in 30% of AF patients
 - can be both a consequence and a cause of AF
- valvular heart disease – present in 30% of AF patients [2]
- cardiomyopathies – carry an increased risk for AF, especially in young patients
- surgery, especially cardiothoracic operations such as thoracotomy and coronary artery bypass graft
- overt thyroid dysfunction – can be the sole cause of AF and may predispose to AF-related complications
- obesity
- lifestyle factors, such as:
 - excessive alcohol consumption
 - excessive caffeine consumption
 - emotional or physical stress
- sleep apnoea – may be a pathophysiological factor for AF due to apnoea-induced increases in atrial pressure and size, or autonomic changes

Prognosis:

- the adverse effects of AF are the result of both: haemodynamic changes related to the rapid and/or irregular heart rhythm; and thromboembolic complications related to a prothrombotic state associated with the arrhythmia
- AF is commonly associated with, and complicated by, heart failure and stroke [2]:
 - confers a 5-fold increased risk of stroke
 - AF-associated ischaemic strokes are often fatal, and patients who survive are left more disabled and more likely to suffer a recurrence than patients with other causes of stroke
 - the risk of death from AF-related stroke is doubled and the cost of care is increased 1.5-fold
- in terms of the day-to-day effect on the patient's quality of life, AF can result in reduced exercise tolerance and impaired cognitive function
- AF progresses from short, rare episodes, to longer and more frequent attacks [2]:
 - over time (years), many patients will develop sustained forms of AF
 - only a small proportion of patients (2-3%) without AF-promoting conditions will remain in paroxysmal AF over several decades

This Pathway should be used only for patients in which it will influence the patient management. It is to be used as a guide and doesn't replace clinical judgement.

References:

- [1] National Institute for Health and Clinical Excellence (NICE). Atrial fibrillation: national clinical guidelines for management in primary and secondary care. London: NICE; 2006
- [2] Camm AJ, Kirchof P, Lip GP et al. Guidelines for the management of atrial fibrillation: the task force for the Management of Atrial fibrillation of the European Society of Cardiology (ESC). Eur Heart J 2010; 31: 2369-2429.

2 Information and resources

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Quick info:

Patient-centred resources:

- [overview of atrial fibrillation](#)
- [information for patients, family and friends](#) (leaflet)
- [causes and symptoms](#)

General information on heart disease and heart health:

- [types of heart conditions](#)
- heart disease [statistics](#)
- how the heart works - [video clip](#)
- [common tests](#) for heart function and health
- [common treatments](#) for heart conditions
- [glossary](#) of heart words

Healthy living/lowering heart disease risk:

- [Heart Foundation advice on living with heart disease](#)
- Heart Help - a list of Hawke's Bay [cardiac support groups](#)
- [lowering risk and staying well](#)
- [manage your risk](#) of heart disease
- heart -healthy [diet tips](#)
- [healthy living information](#)
- [green prescription](#) information

Medications:

[Patient decision aid](#). Atrial fibrillation: medicines to help reduce your risk of a stroke –what are the options?

Warfarin - what you need to know (printable patient leaflet):

- [English language leaflet](#)
- [Samoan language leaflet](#)
- [Tongan language leaflet](#)
- [Chinese language leaflet](#)

[Patient information about Dabigatran](#)

Rate/rhythm control medications:

- [beta blockers](#)
- [calcium channel blockers](#)
- [Digoxin](#)
- [Amiodarone](#)
- [Flecainide](#)

Language translation assistance:

HBDHB Interpreting Service. To make an appointment (charges may apply):

- phone 06 878 8109 ext.. 5805 or
- email interpreting@hawkesbaydhb.govt.nz

These websites may help with simple words and phrases:

- [Babelfish](#)
- [Google translate](#)

[Language Line](#). Professional interpreters are available, free of charge, for telephone-based sessions (44 languages are supported):

- Phone 0800 656 656
- Monday - Friday 9am - 6pm
- Saturday 9am - 2pm

Bookings are not usually necessary. For longer consultations (for example, a nurse consultation for a newly diagnosed person) it is best to make a booking at least 24 hours in advance by calling the above number or emailing language.line@dia.govt.nz and

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providing your contact details and a summary of the service you require (time and date of the meeting, language, approximate length of the appointment, gender of interpreter (if relevant)).

3 Updates to this care map

Quick info:

Date of publication: December 2015

Date of review and republication: November 2017

Next review due: November 2019

This care map has been developed in line with consideration to evidenced based guidelines.

For further information on contributors and references please see the Pathway's Provenance Certificate

4 Hauora Maori

Quick info:

Maori are a diverse people and whilst there is no single Maori identity, it is vital practitioners offer culturally appropriate care when working with Maori whanau. It is important for practitioners to have a baseline understanding of the issues surrounding Maori health. This knowledge can be actualised by (not in any order of priority):

- considering the importance of introductions ('whanaungatanga') - a process that enables the exchange of information to support interaction and meaningful connections between individuals and groups. This means taking a little time to ask where this person is from or to where they have significant connections
- asking Maori people if they would like their whanau or significant others to be involved in assessment and treatment
- asking Maori people about any particular cultural beliefs they or their whanau have that might impact on assessment and treatment of the particular health issues

Maori health services

HBDHB contracts Maori health providers to deliver community based nursing and social support services. Practitioners should discuss, where appropriate, information about relevant Maori health services. A referral to one of these providers may assist Maori people to feel more comfortable about receiving services following discussions.

Central Hawke's Bay:

[Central Health](#)

Cnr Herbert & Ruataniwha Streets, Waipukurau

Phone: 06 858 9559 Fax: 06 858 9229

Email: reception@centralhealth.co.nz

[Referral Form](#)

Hastings:

[Te Taiwhenua o Heretaunga](#)

821 Orchard Road, Hastings 4156

Phone: 06 871 5350 Fax: 06 871 535

Email: taiwhenua.heretaunga@ttoh.iwi.nz

[Referral Form](#)

Kahungunu Health Services (Choices)

500 Maraekakaho Road, Hastings

Phone: 06 878 7616

Email: kahungunu@paradise.net.nz

[Referral Form](#)

Napier:

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[Te Kupenga Hauora](#)

5 Sale Street, Napier

Phone: 06 835 1840

Email: info@tkh.org.nz

[Referral Form](#)

Wairoa:

Kahungunu Executive (no website)

65 Queen Street, Wairoa 4108

Phone: 06 838 6835 Fax: 06 838 7290

Email: kahu-exec@xtra.co.nz

Secondary care Maori Health Services:

Hawke's Bay DHB - Te Wahanga Hauora Maori Health Services

Phone: 06 878 8109 ext. 5779, 06 878 1654 or 0800 333 671 Email: admin.maorihealth@hawkesbaydhb.govt.nz

Further Information

Practitioners should be versed in the knowledge of:

- historical overview of legislation that impacted on Maori well-being
- Maori models of health, such as [Te Whare Tapa Wha](#) and Te Wheke when working with Maori whanau
- national Maori Health Strategies:
 - **Mai Maori Health Strategy 2014-2019** - [Full file](#) or [Summary diagram](#)
 - **He Korowai Oranga:** Maori Health Strategy - sets the [Government's overarching framework](#) to achieving the best health outcomes for Maori
- local [Hawke's Bay health sector's strategies and initiatives](#) for improving Maori health and wellbeing
- [Medical Council of New Zealand competency standards](#)

Cultural Competency Training

Training is available through the Hawke's Bay DHB to assist you to better understand Maori culture and to better engage with Maori people. Contact the coordinator

Email: education@hbdhb.govt.nz to request details of the next courses.

5 Pasifika

Quick info:

Pacific people value their culture, language, families, education and their health and wellbeing. Many Pacific families have a religious affiliation to a local church group.

The Pacific people are a diverse and dynamic population:

- more than 22 nations represented in New Zealand
- each with their own unique culture, language, history, and health status
- share many similarities which we have shared with you in order to help you work with Pacific people more effectively
- for many families language, cost and access to care are barriers

Pacific ethnic groups in Hawke's Bay include Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau, Kiribati and Tuvalu. Samoan and Cook Island groups are the largest and make up two thirds of the total Pacific population. There is a growing trend of inter-ethnic relationships and New Zealand born Pacific populations.

Acknowledge [The FonaFale Model](#) (Pacific model of health) when working with Pacific people and families.

General guidelines when working with Pacific people and families (information developed by Central PHO, Manawatu):

- [Cultural protocols and greetings](#)
- [Building relationships](#) with your Pacific people
- [Involving family support and religion](#) during assessments and in the hospital
- [Home visits](#)

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Hawke's Bay-based resources:

- [HBDHB interpreting service website](#) or phone 06 8788 109 ext. 5805 (no charge for the hospital; charges may apply for community-based translations) or contact coordinator at interpreting@hbdhb.govt.nz
- Pacific Navigation Services Ltd Phone: 027 971 9199
- services to assist Pacific people to access healthcare ([SIA](#))
- [Improving the Health of Pacific People in Hawke's Bay](#) - Pacific Health action Plan

Ministry of Health resources:

- [Ala Mo'ui](#) Pathways to Pacific Health and wellbeing 2014-2018
- [Primary Care for Pacific people](#): a Pacific and health systems approach
- Health education resources in [Pacific languages](#) (links to a web page where you can download resources)

6 Advance care planning

Quick info:

Advance Care Planning:

Advance Care Planning is a voluntary process of discussion and shared planning for future health care. It involves the person who is preparing the plan, and usually involves family/whanau and health care professionals.

Advance Care Plan:

An Advance Care Plan is the outcome of Advance Care Planning. It is formulated by the person and sets out their views about care towards the end of their life. It may also include views about medical care and a wide range of other matters. An Advance Care Plan may include an Advance Directive.

Advance Directive:

An Advance Directive is a statement a person makes about their medical care in the future and becomes effective if a person ceases to be competent to make decisions for themselves. An Advance Directive is legally binding if made in appropriate circumstances.

Competency and Advance Care Planning:

Competent people have the right to make autonomous decisions that as medical professionals we may regard as imprudent, and sometimes such decisions are a reflection of the person's longstanding personality, beliefs or lifestyle. This right is described in the Health and Disability Consumers Rights Acts.

According to ACP - A Guide for the NZ Health Care Workforce - "in the context of ACP, competency relates to an individual's ability to make a decision regarding their own health care (that is, competence at decision-making or decision-capacity). At a minimum, decision making capacity requires the ability to understand and communicate, to reason and deliberate, and the possession of a set of values".

Helpful websites:

- [The code of rights](#)
- [Advance care planning guide Ministry of Health](#)
- [Advance care planning resources](#)

7 Atrial Fibrillation (AF) Clinical Presentation

Quick info:

Asymptomatic Atrial Fibrillation (AF) is relatively common. Many asymptomatic patients are picked up in general practice:

- may be discovered incidentally by cardiac auscultation
- 12-lead ECG recording
- or 24-hour Holter recording

In some cases, asymptomatic AF may only be detected when the patient presents with serious complications, such as a stroke, thromboembolism, or heart failure:

- whether AF was the cause or effect of the acute problem may then be uncertain

Symptomatic presentation:

- the patient may present with a wide variety of cardiac and non-cardiac conditions [1]
- common symptoms include:
 - breathlessness/dyspnoea

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- palpitations
- chest pain/discomfort
- syncope/dizziness
- fatigue
- polyuria may occur due to the release of atrial natriuretic peptide during episodes of AF
- in extreme cases, the patient may present with loss of consciousness

References:

[1] National Institute for Health and Clinical Excellence (NICE). Atrial fibrillation: national clinical guidelines for management in primary and secondary care. London: NICE; 2006

8 Red flags

Quick info:

Refer to Emergency Department for urgent assessment if the person has any of the following:

- a rapid pulse (greater than 150 bpm) and/or low blood pressure (systolic blood pressure less than 90mmHg)
- loss of consciousness, severe dizziness, ongoing chest pain, or increasing breathlessness
- a complication of AF, such as stroke, transient ischaemic attack (TIA) or acute heart failure

9 History and Examination

Quick info:

Discuss the following:

- the presence and nature of symptoms associated with Atrial Fibrillation (AF), including:
 - palpitations – establish:
 - onset and duration
 - frequency
 - pattern
 - speed
 - chest pain
 - breathlessness
 - pre syncope/syncope
 - fatigue
 - confusion
 - flushes
 - nausea
 - sweating
 - reduced exercise capacity
- precipitating factors, such as:
 - stimulants, e.g. tobacco, coffee, tea, **alcohol**
 - exercise
 - intercurrent acute illness e.g. infection

Physical examination:

- assess pulse both at rest and on exertion
- check BP
- apical-radial deficit

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10 Electrocardiogram

Quick info:

A 12 Lead ECG should be performed in all patients, whether symptomatic or not, in whom Atrial Fibrillation (AF) is suspected because an irregular pulse has been detected [1].

If diagnosis remains unclear, discuss ECG with cardiologist (Mon - Fri 8 - 5pm phone 06 8788 109 - hospital switchboard to transfer call).

If after hours, contact the ED Consultant or physician on-call.

A typical ECG trace for AF would include [2]:

- no distinct P-waves visible
- variable and completely irregular baseline – best seen in V1
- irregularly-spaced narrow QRS complexes – unless patient has a bundle branch block

In patients with suspected symptomatic AF (not palpitations) in whom initial ECG is negative, consider additional ambulatory ECG monitoring:

- if symptoms every day, order a holter monitor through e-referral or usual referral process to Cardiology department at Hawke's Bay Regional hospital.
- if symptoms less frequent order an event recorder
- if symptoms are prolonged (e.g. several hours) local 12 lead ECG at Primary Care practice

References:

[1] National Institute for Health and Clinical Excellence (NICE). Atrial fibrillation: national clinical guidelines for management in primary and secondary care. London: NICE; 2006

[2] Camm AJ, Kirchof P, Lip GP et al. Guidelines for the management of atrial fibrillation: the task force for the Management of Atrial fibrillation of the European Society of Cardiology (ESC). Eur Heart J 2010; 31: 2369-2429.

11 Consider Differential Diagnoses

Quick info:

The following may present with a rapid irregular pulse and mimic Atrial Fibrillation (AF) [3]:

- atrial tachycardias
- atrial flutter
- ectopic activity

An ECG recording during the arrhythmia will usually differentiate the common diagnosis of AF from other rare supraventricular rhythms with irregular RR intervals, or the common occurrence of ventricular extrasystoles.

References:

[3] Clinical Knowledge Summaries (CKS). Atrial fibrillation. August 2009. Newcastle upon Tyne: CKS; 2009.

12 Duration < 48hrs

Quick info:

If duration is < 48hrs, then pharmacological or synchronised electrical cardioversion may be considered in secondary care.

Although most patients in Atrial Fibrillation (AF) present without haemodynamic compromise, some are significantly compromised and require immediate hospitalisation and urgent intervention to:

- alleviate symptoms of breathlessness, chest pain, and loss of consciousness
- restore haemodynamic stability

Patients at the greatest risk from haemodynamic instability are those with:

- **a ventricular rate greater than 150bpm**
- **ongoing chest pain**
- **critical perfusion**

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Refer to Emergency Department for urgent assessment if the person has any of the following:

- a rapid pulse (greater than 150 bpm) and/or low blood pressure (systolic blood pressure less than 90mmHg)
- loss of consciousness, severe dizziness, ongoing chest pain, or increasing breathlessness
- a complication of AF, such as stroke, transient ischaemic attack (TIA) or acute heart failure

13 Investigations

Quick info:

Consider the following routine investigations:

- complete blood count (CBC)
- thyroid stimulating hormone (TSH)
- sodium and potassium
- [creatinine/eGFR clearance \(Cockcroft Gault Equation\)](#)
- glucose
- liver function test (LFT)
- INR (if warfarin is to be initiated)
- chest X-ray
- troponin if ischaemia cannot be ruled out
- echocardiography (referral to outpatient cardiology):
 - useful test to guide ongoing therapeutic strategies, but unlikely to be of benefit in individuals with advanced co-morbid conditions where this will not alter management

Rationale for suggested tests:

- CBC to exclude anaemia or infection
- TSH to exclude hyperthyroidism
- electrolytes to exclude underlying metabolic abnormalities
- creatinine/eGFR to check renal function :
 - if considering dabigatran the calculated creatinine clearance is more accurate
- glucose to exclude diabetes
- LFT prior to anticoagulation or high alcohol intake
- chest X-ray in cases where shortness of breath is a significant feature as heart failure may co-exist or there may be other lung pathology
- echocardiography to rule out structural heart disease

14 Consider Causes of Atrial Fibrillation

Quick info:

Consider causes of Atrial Fibrillation (AF):

- often caused by co-existing medical conditions – both cardiac and non-cardiac
- common cardiac causes include:
 - ischaemic heart disease
 - rheumatic heart disease - specifically mitral valve disease
 - hypertension
 - sick sinus syndrome
- less common cardiac causes include:
 - cardiomyopathy or heart muscle disease
 - pericardial disease, including effusion and constrictive pericarditis
 - atrial septal defect
 - atrial myxoma

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- non-cardiac causes include:
 - acute infections, especially pneumonia
 - electrolyte depletion
 - lung carcinoma
 - other intrathoracic pathology, e.g. pleural effusion
 - pulmonary embolism
 - thyrotoxicosis

Risk factors include:

- increasing age:
 - the prevalence of AF roughly doubles with each advancing decade of age, from 0.5% at age 50–59 years to approximately 10% at age 80 years [1]
 - AF is very uncommon in infants and children, unless concomitant structural or congenital heart disease is present [1]
- Maori or Pacific Ethnicity
- diabetes
- hypertension
- valve disease
- all surgery, especially cardiothoracic operations such as thoracotomy and coronary artery bypass graft
- lifestyle factors, such as:
 - excessive alcohol consumption
 - excessive caffeine consumption

References:

[1] National Institute for Health and Clinical Excellence (NICE). Atrial fibrillation: national clinical guidelines for management in primary and secondary care. London: NICE; 2006

15 Transfer to Emergency Department

Quick info:

The referring clinician is required to arrange the transfer of care.

A clinical handover should take place with the necessary clinical documentation faxed to ED (06 878 1353) and the original sent with the patient:

- ECG (include the most recent ECG if relevant)
- referral letter or electronic discharge summary from rural site

Please Note: The Emergency Department requires formal documentation (clinical assessment, investigations and working diagnosis/ problem list and any intervention to date).

16 Ambulatory Monitoring

Quick info:

In patients with suspected paroxysmal Atrial Fibrillation (AF) undetected by standard ECG recording:

- a 24-hour ambulatory ECG monitor should be used in those with symptomatic episodes less than 24 hours apart
- an event recorder ECG should be used in those with symptomatic episodes more than 24 hours apart

Ambulatory monitoring available:

- 24-hour Holter Monitor
- 2-week Event Recorder

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17 Clinical Evaluation

Quick info:

Atrial Fibrillation (AF) is generally classified into three types, although this may require further investigations and cardiologist input to determine. Knowing the type helps to guide treatment decisions regarding rate or rhythm control.

The three types are:

- **Paroxysmal AF** - characterised by recurrent episodes of AF that last less than seven days (although often less than 24 hours) and resolve spontaneously within that time. Rhythm control is the preferred treatment
- **Persistent AF** - characterised by episodes of AF that last more than seven days and that has not spontaneously resolved within this time. Treatment is rate and rhythm control depending on the individual patient situation
- **Permanent AF** - AF that has been present for more than one year and cardioversion has failed or not been attempted. Rate control is preferred

Clinical evaluation should ideally include determination of the European Heart Rhythm Association (EHRA) score:

- EHRA class I – no symptoms
- EHRA class II – mild symptoms, normal daily activity not affected
- EHRA class III – severe symptoms, normal daily activity affected
- EHRA class IV – disabling symptoms, normal daily activity discontinued

NB: The EHRA score only considers symptoms that are attributable to AF and reverse or reduce upon restoration of sinus rhythm or with effective rate control [3].

Lone AF [1]:

- refers to AF without overt structural heart disease
- only considered as a diagnosis of exclusion if there is:
 - no history of cardiovascular disease or hypertension
 - no abnormal cardiac signs on physical examination
 - a normal chest x-ray and, apart from the presence of AF, a normal ECG – ie no indication of prior myocardial infarction or left ventricular hypertrophy

Stroke risk in lone AF patients:

- there are implications of labelling patients with a diagnosis of lone atrial AF, as this group is often considered to be at 'low risk', despite the fact that recent data have been inconclusive [1]
- lone AF patients who are under age 60 years carry a very low cumulative stroke risk, estimated to be 1.3% over 15 years [3]
- the probability of stroke in young patients with lone AF appears to increase with advancing age or development of hypertension, emphasizing the importance of re-assessment of risk factors for stroke over time [3]

References:

[1] National Institute for Health and Clinical Excellence (NICE). Atrial fibrillation: national clinical guidelines for management in primary and secondary care. London: NICE; 2006

[3] Clinical Knowledge Summaries (CKS). Atrial fibrillation. August 2009. Newcastle upon Tyne: CKS; 2009.

18 Paroxysmal Atrial Fibrillation (AF)

Quick info:

Paroxysmal Atrial Fibrillation (AF):

- is characterised by recurrent episodes of AF that last less than seven days (although often less than 24 hours) and resolve spontaneously within that time
- may present symptomatically or asymptotically
- may require rate control drugs (e.g. metoprolol or diltiazem)

NB: Digoxin is not recommended in paroxysmal AF

If considering antiarrhythmic drugs seek advice from Cardiologist. The chances of maintaining sinus rhythm or substantially reducing the paroxysms of AF are considerably higher than in persistent atrial AF owing to better preservation of atrial function [1]

References:

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[1] National Institute for Health and Clinical Excellence (NICE). Atrial fibrillation: national clinical guidelines for management in primary and secondary care. London: NICE; 2006

19 Persistent / Permanent Atrial Fibrillation (AF)

Quick info:

Persistent Atrial Fibrillation (AF) is characterised by episodes of AF that last more than seven days and that has not spontaneously resolved within this time.

Permanent AF is characterised by AF that has been present for more than one year and cardioversion has failed or not been attempted.

Atrial fibrillation (AF) Provenance Certificate – review and republish

Overview

This document describes the provenance of Hawke's Bay's District Health Board's Atrial fibrillation Pathway. It was developed in June - August 2015 and first published in December 2015. A review of this pathway was completed by the clinical leads in September 2017 and was re-published in November 2017. A further review of the Pathway is due in November 2019.

The Collaborative Clinical Pathways programme is one initiative stemming from the *Transform and Sustain* agenda. The main aims of CCP are to:

- Identify opportunities to improve how health and disability care is planned and delivered within the district to improve patient access to a wider range of health services that are both closer to home and reduce avoidable hospital admissions.
- Provide health professionals throughout the Hawke's Bay district with best practice, evidence-based clinical pathways that are available at the point of care.

Outcomes we expect to achieve include faster access to definitive care, improved health equity and outcomes, better value from publically-funded resources, and better patient experience through clear expectations, improved access and greater health literacy. These outcomes are clearly aligned to the NZ healthcare *Triple Aim* and *Better, Sooner, More Convenient* policy directions.

Editorial methodology

This Pathway was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of Medicine editorial methodology. It was developed by individuals with front-line clinical experience (see Contributors section of this document) and has undergone consultation to gain feedback and input from the wider clinical community.

Map of Medicine Pathways are constantly updated in response to new evidence. Continuous evidence searching means that Pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the Pathways through the quarterly publication cycle.

An update to this Pathway is scheduled for 12 months after first publication. However, feedback is welcomed at any time, with important updates added at the earliest opportunity within the Map of Medicine publishing schedule (the third Friday of each month).

References

This Pathway has been developed according to the Map of Medicine editorial methodology. Its content is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. Feedback on this Pathway was received from stakeholders during a consultation process.

1	National Institute for Health and Clinical Excellence (NICE). Atrial fibrillation: national clinical guidelines for management in primary and secondary care. London: NICE; 2006
2	Camm AJ, Kirchof P, Lip GP et al. Guidelines for the management of atrial fibrillation: the task force for the Management of Atrial fibrillation of the European Society of Cardiology (ESC). Eur Heart J 2010; 31: 2369-2429.
3	Clinical Knowledge Summaries (CKS). Atrial fibrillation. August 2009. Newcastle upon Tyne: CKS; 2009.
4	National Institute for Health and Clinical Excellence (NICE). Assessment and diagnosis of recent onset chest pain or discomfort of suspected cardiac origin. Clinical guideline 95. London: NICE; 2010.
5	Fauci AS, Braunwald E, Kasper DL et al. Harrison's Principles of internal medicine. 17th edn. London: McGraw Hill Medical; 2008
6	Map of Medicine (MoM) Clinical Editorial team and Fellows. London: MoM; 2011.

Contributors

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- Sue Revell, ED Nurse, HBDHB
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Review completed by:

- Stefan Freudenberg, GP, The Doctors Napier (Primary Lead)
- Keith Dyson, Cardiologist, HBDHB (Secondary Lead)

Map editing and facilitation

- Penny Pere (original pathway facilitator)
- Belinda Sleight (original pathway editor)
- Louise Pattison (pathway review)

Disclaimers

Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay

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